BEHAVIORAL/MENTAL HEALTH

Behavioral/Mental Health

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HIGHLIGHTS FROM BEHAVIORAL/MENTAL HEALTH

The following information highlights the findings from the Orange County Health Needs Assessment (OCHNA) survey as they pertain to behavioral /mental health.

- The National Institute of Mental health estimates that more than one fifth of all adults in the United States suffer from mental disorders in any given year. In addition, the highest rates of diagnosable mental disorders are found among groups with the lowest socioeconomic status. According to Healthy People 2000 Review (1997), 22% of adult Americans will have some form of diagnosable mental disorder during their lifetime.

- Five percent of all OCHNA survey respondents reported having a mental disorder, with a significantly higher percentage (9.1%) reporting in the low income category. The majority of those considered their condition to be a "moderate" to "serious" threat.

- Survey respondents from the low income category were significantly more likely than those in the high income category to feel "quite a bit" or "extremely" distressed, nervous, and irritable.

- Cultural factors may also play a role in affecting a person's attitude and response to mental health.

- The stigma of mental disorders prevents people from seeking treatment. According to the Mental Health Association, one third of people seeking treatment reported being turned down for health insurance coverage because of their mental condition.

- In Orange County between 1994 and 1996, there was an average of 8.6 deaths by suicide per 100,000 people. This is below the Healthy People 2000 goal of 10.5 deaths per 100,000. Unreported or unsubstantiated suicides (accidents, motor vehicle deaths, police shootings, etc.) accounted for an unknown number of additional deaths that might be attributed to suicide. The National Center for Health Statistics showed that from 1950 to 1995, no progress was made in reducing the incidence of suicide.

- Orange County Health Care Agency (HCA) data indicated that 27% of hospital discharges for blacks in Orange County in 1996 were in the diagnostic category of psychosis although blacks accounted for only 3% of all Orange County hospital discharges.

- Whites accounted for 79% of hospital discharges in the diagnostic category of psychosis; Latino/Hispanics, 9%; and Asians, 3%.

- Nearly one fourth of respondents reporting a mental disorder are not receiving treatment. One third cited "no reason to go" as their reason for not having received or never having received treatment.

- Nearly 4% of respondents reported 30 days of poor mental health within the past 30 days. A significantly higher percentage (6.9%) of those responses came from the low income category.

- Three out of 4 respondents in a study conducted by Otto Wahl, Ph.D., of George Mason University, and released by the National Alliance for the Mentally Ill said they did not disclose their illness to anyone but their close family members.

Focus Group Comments

Focus group participants had some interesting input on the topic of behavioral/mental health. Below are some quotes taken from various focus group participants on topics central to behavioral /mental health.

Teens in the children's focus group felt that behavorial/mental health is an integral part of being a "healthy" person.

> *It's a mental health [thing], too.... If you don't love yourself, then you could be considered not healthy. (2:4)*

Teens also expressed struggling with issues of depression and suicidal thoughts and a desire for support groups to help them deal with such feelings.

> *A lot of people go through it [depression]. I mean... say, for instance relationships. (2:40-41)*

> *...They should have classes or support groups about people who want to kill themselves." (2:40-41)*

One provider had this to say about insurance coverage of mental health services:

> *Well,... even the coverage... employers offer.... in terms of the behavioral/mental health area, a lot of the smaller employers don't cover it. Although it may even be mandatory now, but I'm not sure if it is. Even still,... in terms of reimbursement, they only cover 50% of the cost or they limit the amount of visits. (1:8)*

One participant voiced the following concern regarding behavioral /mental health services.

> *Depression, anxiety, panic attacks. We don't have the service, and it's just amazing that we don't have [those services] in Orange County. (1:34)*

Providers in the Cultural Issues in Behavioral/Mental Health focus group had the following input on the immigrant population.

> *I find this population is in great need of knowing how to access the [mental] health... services that they need,... maybe for a lack of language or transportation. (3:4)*

> *With the Cambodian ...[population], [service providers] need to provide translation and transportation... especially for women clients. (3:5)*

One participant in a senior focus group also spoke about cultural issues related to behavioral /mental health.

> *I find one of my friends is like that [depressed]. He came here from Vietnam to live with his three daughters and his son who is mentally deficient. Life here is different from that in Vietnam and he became nervous. Now he has entered a mental institution and he doesn't remember anything. (2:14)*

Although few seniors in the focus groups voiced concerns over depression and other mental illness, caregivers for the frail elderly voiced the following concerns regarding the elderly and behavioral /mental health.

> *...Because of depressed elders [there is] an increase in the amount of suicides, especially among men. And we don't think about the fact that some of those suicides may be medication driven and not necessarily a man growing up, growing old and his ego getting out of whack just because he's growing old. (1:22)*

> *...What I see as a big gap is the ... kind of geriatrics-psychiatric interface. And we have clients who have either, you know, traditional mental health or cognitive mental health problems, and they sometimes enter the mental health system and it goes from... from bad to worse as a result of the intervention. (1:18)*
>
> *And if they had proper geriatric mental health services, that intervention would make a world of difference. (1:18)*

What's right with behavioral /mental health care? One provider offered the following opinion:

> *I would say the treatment for depression. You know, in terms of medications available and how effective they are. They're wonderful. I mean... there are plenty of studies that show that treatment of depression is much more effective than treatment of high blood pressure and some other things, that it works really well, and it's safe and effective. I think it's recognized. I think more people are coming in and asking for help than ever have before... realizing... they see other people doing well. They're saying, go get help. Don't wait around. (2:7)*

BEHAVIORAL/MENTAL HEALTH

The National Institute of Mental Health (NIMH) estimates that more than one fifth of all adults in the United States suffers from mental disorders in any given year. For most of these people, the disorders are relatively mild and brief. However, approximately 5 million adult Americans (2.8%) and a similar proportion of children and adolescents suffers from severe mental illnesses such as schizophrenia, bipolar and unipolar affective disorder, schizoaffective disorder, autism, panic disorder, and obsessive-compulsive disorder. Because society fears and misunderstands mental disorders, there is a stigma attached to those who suffer from these afflictions. This stigma limits their access to social supports, services, and resources.

According to Healthy People 2000, 22% of adults will experience some form of diagnosable mental disorder during their lifetime. Five percent of Orange County Health Needs Assessment (OCHNA) survey respondents indicated that they have a "mental condition." This relatively low rate in Orange County may be due to several factors. Healthy People 2000 states, "Too few primary care providers are trained to recognize depression and the variety of disabilities associated with it." Many adults are treated for fatigue, headaches, and anxiety instead of possible underlying depression. Additionally, providers may be focusing too intently on treatment of secondary symptoms of mental health problems such as alcohol and controlled substance abuse. Information from the Behavioral/Mental Health focus group indicated that because people are reluctant to use or are undereducated about available mental health services, they tend to self-medicate with drugs and alcohol. As one of the participants stated, "There's a lot of substance abuse in the workplace but it's not necessarily the primary diagnosis, although we treat it as such.... Another thing that I'm seeing a lot of in the 90s are panic attack disorders that people are self-medicating with alcohol."

Cultural factors may also play a role in affecting a person's attitude and response to mental health. For example, in the 1996 Vietnamese Women's Health Status, Health care Access and Utilization Assessment conducted by the Social Science Research Center and School of Human Development and Community Services at California State University, Fullerton, 45% of the women being interviewed indicated a mental health concern; depression, fear, stress, and anxiety were among the primary complaints. More than 95% of these women reported they "had never received counseling or mental health services." For many in the Orange County ethnic and immigrant communities, cultural assimilation and English language proficiency do not automatically enable these groups to take advantage of available mental health resources. There are certain cultural factors that cause the stigma associated with mental health disorders to produce an even more insurmountable barrier.

Another major obstacle to participation in programs related to behavioral/mental health services is lack of a comprehensive and detailed information source about the various Orange County programs that are available. As discussed in the Behavioral/Mental Health Focus Groups, "The county needs to set up a program to help promote the services that are already there and to help open up those services so that [they] are used appropriately." The participants discussed methods of promoting a "resource directory that exceeds the information provided by the current systems" for primary care providers, and the general public. Effective methods of disseminating the information to ethnic populations were proposed such as Vietnamese radio and television programs, Spanish-language talk shows and tele-novelas, and neighborhood resource groups in Orange County.

Data collected by the Orange County HCA indicated that 27% of all hospital discharges for blacks in Orange County in 1996 were in the diagnostic category of psychosis although blacks accounted for only 3% of all Orange County hospital discharges. Whites accounted for 79% of hospital discharges in the diagnostic category of psychosis, Latino/Hispanics 9%, and Asians 3%. Mental disorders were ranked 18th of the 39 leading causes of death for all Orange County residents.

Mortality rates attributed to mental disorders in Orange County between 1994 and 1996 are shown in the table below.

Population groups	Average number of deaths	Total deaths (%)
All residents	181.3	1.18
All females	97.7	1.25
All males	83.7	1.10
All non-Hispanic whites	158.3	1.23
All non-Hispanic blacks	0.7	0.43
All Latino/Hispanics	16.3	1.17
All southeast Asians	1.3	0.41
All northeast Asians and Pacific islanders	4.0	0.78

Although the percentages may seem minute compared to those of heart disease and cancer, for some populations more deaths can be attributed to mental disorders than to diseases such as AIDS. For example, while 1.25% of all female deaths between 1994 and 1996 were attributed to mental disorders, only .21% were attributed to AIDS.

According to the NIMH, the highest rates of diagnosable mental disorders are found among groups with the lowest socioeconomic status. Although mental illness strikes people of all socioeconomic classes, having a mental disorder may lead to unemployment and homelessness. These conditions affect the propensity toward an impoverished existence. OCHNA survey results supported this finding. Those persons with the lowest incomes felt the most distress, irritation, and nervousness. Eight respondents (2.7%) stated depression, anxiety, and emotional problems as being a "major impairment...that limits any activities of a member of the household (including self)." In addition, those persons in the low income category had a significantly higher incidence of mental disorders, and the majority of those considered the condition to be a "moderate" to "serious" threat.

The OCHNA established 3 focus groups on behavioral/mental health targeting providers, employers, and representatives of cultural issues. As the focus groups noted time and again, the stigma of mental disorders prevents people from seeking treatment. Employee assistance program professionals noted employees lost their jobs or lost status at work if they disclosed any mental impairment. A survey of mental health consumers by Otto Wahl, Ph.D., of George Mason University and released by the National Alliance for the Mentally Ill, found that 70% of the 1,300 respondents felt they were treated as though they were less competent at their workplace after their mental condition was discovered. Three out of 4 persons surveyed said that they do not disclose their illnesses to anyone except close family members. The same survey found the impact of stigma extends beyond the workplace: one third of respondents reported being turned down for health insurance because of their mental condition.

Access to service, particularly health coverage, also limits treatment. Some plans do not cover behavorial/mental health at all while many pay only 50% or specify a maximum dollar amount. The number of visits allowed is also limited. In ethnic and immigrant populations, awareness, language barriers, and access to transportation may be additional obstacles to treatment. The following is an excerpt from the Behavioral/Mental Health Focus Group summary:

> *I think that there is kind of a stigma with behavioral health services....It's easy for employees, associates to access...their physical health benefits through a primary care physician, but it's a maze for employees to access behavioral health services, and we know that the process is absolutely intrusive...there's usually a series of three or four interviews with unknown people, most who are not clinicians and there's a long wait for service....And because the process is so intrusive, most people decline to follow through with it, where perhaps more women are resilient in going through that, either for themselves or other people. In the years*

past, we had indemnity plans, and we could seek mental health on our own. You would just call up and usually use a family physician's referral to a psychiatrist or a clinical psychologist, and we've made that virtually impossible for people.

In 1994 the NIMH estimated that only 16% of Americans diagnosed with a mental disorder sought treatment. Twenty-six percent of OCHNA survey respondents who considered themselves to have a "mental condition" reported "never receiving treatment." Currently, 69% of those who have ever received treatment for a mental disorder are currently receiving treatment. The respondents who are not receiving treatment gave the reasons shown below.

Reason	Never received treatment (%)	Not currently receiving treatment (%)
No reason to go	41.8	33.1
Cost	21.1	29.3
Didn't think of it	8.4	N/A
Do not have or do not know doctor	1.0	7.6
Fear/apprehension	N/A	4.5
Other	27.7	25.4

It is noteworthy that at least one third of those who admitted to a mental condition, but are not or have never received treatment, responded that they have "no reason" for seeking treatment. They may not believe mental disorders are serious or treatable, or they may be reluctant to admit they need help. This supports the finding by the Mental Health Association in California that two thirds of those suffering from depression do not seek treatment. In fact, 15% of those with depression commit suicide without ever seeking help.

In Orange County between 1994 and 1996, suicide accounted for an average rate of 8.6 deaths per 100,000 people. Although this is below the Healthy People 2000 guideline of 10.5 deaths by suicide per 100,000 people, it warrants attention. Unreported suicides (accidents, motor vehicle deaths, police shootings, etc.) also account for an unknown number of additional deaths.

Data collected by the Orange County HCA, California Department of Health Services, and the California Department of Finance shows the suicide rates per 100,000 people.

Orange County	California	United States	Healthy People 2000
8.6	10.7	11.2	10.5

Even with advances in medicine, progress related to reducing suicide rates has been slow. The National Center for Health Statistics shows that from 1950 to 1995, no progress was made in reducing the incidence of suicide. The suicide rate in 1950 was 11 suicides per 100,000 people. In 1995, the suicide rate was 11.2 per 100,000 people. During this same period the total number of deaths by any cause decreased 40%, while deaths by suicide remained constant.

Treatment is effective for the majority of mental disorders. For example, depression can be treated successfully in 80% of patients. In addition to medication, people suffering from mental illness can be treated by psychiatric or psychosocial rehabilitation. This treatment philosophy emphasizes consumer strengths and has been shown to significantly reduce hospitalizations, increase participants' level of functioning and level of independent living, increase client satisfaction, and increase the rate of employment for participants.

According to the NIMH, in 1990 mental disorders of all types cost the nation an estimated $148 billion. Of this amount, $67 billion was attributed to direct treatment; the remainder accounted for the social costs of these illnesses that reduce life expectancy, lessen productivity, and increase demands on the social service and criminal justice systems. The significant costs associated with mental health underscore the importance of preventive measures. Studies show that social support protects healthy people from the negative emotional consequences associated with stressful life events, helps people with clinical depression maintain their treatment gains, improves recovery from physical illness, and helps people with schizophrenia function in the community while lessening the chance of relapse. Social networks increase the flow of information, material assistance, and other resources to individuals.